Bedford Board of Health
2014 - 2015 Insurance Information Form

Information about the person to receive vaccine (please print): *Required Fields

Name: (Last, First, MI)*	Date of birth: * Month Day Year	Age*	Sex: (Circle)* Male Female
Street Address:*			
City:*	State: *	Zip:*	Phone:* ( )

Insurance Information: *Include the whole member ID number and any letters that are part of that number*

Name of Insurance Company:*	Member ID Number:*	Group ID Number: (if available)
Medicare Number:	Is Medicare Primary? Yes No	Is Subscriber Employed? Yes No

If person getting vaccinated is not the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: * Month Day Year	Sex: (Circle)* Male Female
Subscriber's Street Address:* (If different from address above)		
City:*	State:*	Zip: *	Phone:* ( )
Patient Relationship to Subscriber: (Circle)* Spouse Child Other		

For Everyone, please circle response:

1. Is the person receiving the vaccine sick today? **Y N**
2. Does the person to be vaccinated have an allergy to eggs ? **Y N**
3. Has the person to be vaccinated ever had Guillain-Barré syndrome? **Y N**
4. Has the person to be vaccinated ever had a serious reaction to the flu vaccine? **Y N**

For Children 18 and Under, please check the box next to any statements that are applicable:

Vaccine Recipient:

- ☐ Is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled through Medicaid)
- ☐ Does not have health insurance
- ☐ Is American Indian (Native American) or Alaska Native
- ☐ Has health insurance and is not American Indian (Native American) or Alaska Native

I give permission for my insurance company to be billed. I acknowledge that I (or my child) will receive the Flu Vaccine and I have received the Vaccine Information Sheet, dated August 19, 2014.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

For Clinic/Office Use Only:

Date of Service	Vax Type	Vax Mfgr	Lot No	Exp Date	Dose (mL)	State Supplied	Preserv Free	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS given
								IM	R Arm L Arm R Leg L Leg		

Clinic Site Name: Bedford Board of Health MDPH Provider PIN#: 10119

Clinic Address: Town of Bedford- BOH 12 Mudge Way, Bedford, MA, 01730

Signature of Vaccine Administrator: _____ Date: _____